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Contents

New Rotavirus VFC Benefit: CPT-4 Code 90680

Effective July 1, 2006, CPT-4 code 90680 (rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use) is a Vaccines For Children (VFC) program benefit. Providers will be reimbursed for the administration of this vaccine by using code 90680 with modifier -SL.

The vaccination series consists of three ready-to-use liquid doses of rotavirus vaccine administered orally to infants. The first dose should be administered at 6 to 12 weeks of age; followed by doses given at four- to ten-week intervals. It may be administered concomitantly with other childhood vaccines. No safety or efficacy data are available for immunocompromised patients, or for use at less than 6 weeks of age or after 32 weeks of age. The Advisory Committee on Immunization Practices (ACIP) recommends a dosing schedule of 2, 4 and 6 months of age.

The updated information is reflected on manual replacement pages inject list 16 (Part 2), inject vacc 1 (Part 2), non ph 11 (Part 2), tar and non cd9 1 (Part 2) and vaccine 3 and 6 (Part 2).

New VFC Benefit: CPT-4 Code 90710

Effective July 1, 2006, CPT-4 code 90710 (measles, mumps, rubella and varicella vaccine [MMRV], live, for subcutaneous use) is a Vaccines For Children (VFC) program benefit. Providers will be reimbursed for this vaccine by using code 90710 with modifier -SL. MMRV may be used for children 12 months to 13 years of age who need a first or second dose of measles, mumps, rubella (MMR) and varicella vaccine.

The updated information is reflected on manual replacement pages inject list 11 (Part 2), inject vacc 1 (Part 2), tar and non cd9 1 (Part 2) and vaccine 3 and 6 (Part 2).

VFC Hepatitis A Reimbursement Policy Update

Vaccines For Children (VFC) policy for billing the administrative fee for Hepatitis A vaccine is updated as follows. The policies below are effective for dates of service on or after July 1, 2006.

- CPT-4 code 90634 (hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use) is discontinued as a benefit.
- Modifier -SK (high risk) and associated documentation are no longer required when billing with CPT-4 code 90633 (hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use). Modifier -SL (state-supplied vaccine) is still required. CPT-4 code 90633 is reimbursable for recipients 1 through 18 years of age (rather than the previous 2 through 18 years of age stated in the provider manual).

Please see **Hepatitis A**, *page 2*

Hepatitis A *(continued)*

The California Department of Health Services recommends that providers begin Hepatitis A immunization with the 2-dose vaccine at 12 months of age with a second dose 6 to 18 months later.

This information is reflected on manual replacement pages inject 10 (Part 2), inject list 9 (Part 2), inject vacc 1 (Part 2), tar and non cd9 1 (Part 2) and vaccine 3 and 5 (Part 2).

Immune Serum Globulin Billing Criteria Update

Effective for dates of service on or after July 1, 2006, immune serum globulin I.V., 1 gram (CPT-4 code 90283) is reimbursable with prior authorization for disorders that have documented evidence of improvement with its use.

An approved *Treatment Authorization Request* (TAR) must be submitted to the local Medi-Cal field office with either of the following:

- A laboratory report documenting an immune globulin level of less than 300 mg/dL for conditions with primary immune globulin deficiency, or
- Documentation supporting the diagnosis of a disorder ameliorated by the use of immune serum globulin I.V., along with any previous treatment regimens and their efficacies and a new treatment plan.

Approved TARs will authorize administration of a specific number of grams, shown in the *Quantity* column.

This information is reflected on manual replacement pages inject 38 and 39 (Part 2).

'Store-and-Forward' Reimbursable for Teleophthalmology, Teledermatology

Effective for dates of service on or after July 1, 2006, "store-and-forward technology" is reimbursable when used for the following teleophthalmology and teledermatology services:

CPT-4 Codes	Description
99211 – 99214	Office or other outpatient visit
99231 – 99233	Subsequent hospital care
99241 – 99243	Office consultation, new or established patient
99251 – 99253	Initial inpatient consultation

"Teleophthalmology and teledermatology by store-and-forward" is defined as an asynchronous transmission of medical information to be reviewed at a later time at a distant site by a physician who is trained in ophthalmology or dermatology, where the physician at the distant site reviews the medical information without the patient being present in real-time.

Providers billing for teleophthalmology or teledermatology with store-and-forward technology must use modifier -GQ (service rendered by store-and-forward telecommunications system). Only services rendered from the distant site are billed with modifier -GQ. The use of the modifier does not alter reimbursement.

Please see **Store-and-Forward**, *page 3*

Store-and-Forward *(continued)*

Store-and-forward teleophthalmology and teledermatology services must meet the following requirements:

- Images must be specific to the patient's condition and adequate for meeting the definition of the CPT-4 code billed.
- Store-and-forward teleophthalmology and teledermatology must be rendered by a physician who completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology, respectively.
- A patient receiving teleophthalmology or teledermatology by store-and-forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store and forward, upon request. If requested, communication with the distant specialist physician must occur within 30 days of the patient's notification of the results of the consultation.
- The provider shall comply with the informed consent provision of the *Business and Professions Code,* Section 2290.5, subdivisions (c) through (g), and subdivisions (i) and (j).
- Teleophthalmology and teledermatology do not include single-mode consultations by telephone calls, images transmitted via facsimile machines or electronic mail.
- Providers are not required to document medical necessity or cost effectiveness to be reimbursed for telemedicine services. However, providers must indicate the barrier to face-to-face visit in the *Reserved For Local Use* field (Box 19), or on an attachment. Examples of barriers include, but are not limited to:
  - Local provider unavailable
  - Local provider wait time unacceptable
  - Local provider unwilling to accept Medi-Cal
  - Local provider unable to address lingual or cultural needs of patient
  - Transportation unavailable
  - Time off work for travel creates a financial or personal hardship

Ophthalmology and dermatology services provided at the originating site at the time of a store-and-forward telemedicine transaction should continue to be billed without a -GQ modifier.

The updated information is reflected on manual replacement pages medne tele 2, 3 and 7 (Part 2) and modif app 4 (Part 2).

Family PACT Clinical Services and Pharmacy Benefit Update

Effective for dates of service on or after August 1, 2006, Family PACT (Planning, Access, Care and Treatment) is implementing diagnosis and procedure code changes. These changes are due to the 2005 and 2006 updates to the *International Classifications of Diseases, 9th Revision, Clinical Modification, 6th Edition* (ICD-9) codes; *Current Procedural Terminology – 4th Edition* (CPT-4) codes; changes to program benefits; and new restrictions for other services.

In addition, Family PACT is adding and deleting drugs from the Family PACT Pharmacy Formulary for dispensing at pharmacies and by clinicians. These changes will bring Family PACT more in line with Medi-Cal billing policies and procedures. Family PACT claims will no longer require paper attachments and therefore can be filed electronically, with the exception of sterilization services, which require the attachment of the *Consent Form* (PM 330).

Please see **Family PACT**, *page 4*

Family PACT *(continued)*

The Family PACT Program has changed from using ranges of ICD-9 codes for secondary diagnoses for sexually transmitted infections (STIs) to short, specific lists that include codes for presenting symptoms and for exposure to infection. Providers should select from the ICD-9 codes published in the *2006 Provisional Clinical Services Benefits Grid* in this bulletin. Accurate ICD-9 secondary diagnosis coding is required for reimbursement of diagnostic tests performed onsite and by laboratories, and for reimbursement of miscellaneous drugs (Z7610) dispensed onsite.

The billing requirements for diagnosis and treatment of urinary tract infection (UTI) and cervical dysplasia, previously defined as concurrent core services, is changed to secondary core services. Providers are instructed to enter appropriate UTI and/or dysplasia diagnoses as secondary diagnosis codes in the appropriate area of the *HCFA 1500* claim form (Box 21) according to Medi-Cal billing and policy. Additionally, with the inclusion of the highly specific diagnoses codes for cervical abnormalities noted as follows, cytology report attachments are no longer required.

Additions
The following ICD-9 codes have been added to the Family PACT Program:

599.7, 604.90, 608.89, 615.0, 616.10, 616.50, 622.2, 788.1, 788.41, 789.09, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.09 and V01.6.

An S-code primary diagnosis is required on all claims and a secondary diagnosis is required for reimbursement of certain diagnostic tests, procedures or drugs dispensed onsite. (See the *2006 Provisional Clinical Services Benefits Grid* for appropriate use of ICD-9 secondary diagnosis codes.)

The following drugs and strengths are added as Family PACT Pharmacy Formulary benefits:

- Azithromycin (500mg tablets)
- Butoconazole Nitrate (2 percent vaginal cream 5gm)
- Clindamycin (2 percent vaginal cream 5.8gm)
- Estradiol (0.5mg tablets)
- Estradiol (1mg tablets)
- Estradiol (2mg tablets)
- Podofilox (topical solution 0.5 percent)
- Tinidazole (250mg tablets)

  Note: Restricted to a maximum quantity per dispensing of eight (8) tablets and a maximum of two (2) dispensings in any 30-day period by the same provider/any rendering.

- Tinidazole (500mg tablets)

  Note: Restricted to a maximum quantity per dispensing of four (4) tablets and a maximum of two (2) dispensings in any 30-day period by the same provider/any rendering.

CPT-4 code 56605 (biopsy of vulva or perineum, separate procedure; one lesion), 87255 (virus isolation; inoculation of embryonated eggs, or small animal, including identification by non-immunological method, other than by cytopathic effect), 87273 (herpes simplex virus type 2) and 93000 (electrocardiogram) have been added as benefits. (See the *2006 Provisional Services Benefits Grid* for appropriate use and restrictions.)

Please see **Family PACT**, *page 5*

Family PACT *(continued)*

The table below shows the correct gender and diagnosis codes necessary for reimbursement for the new drugs listed above if dispensed onsite using HCPCS code Z7610:

Drug	Gender	Primary Diagnosis Code	Secondary Diagnosis ICD-9 Code	Additional Restrictions
Azithromycin 500mg tablets	Both	All except S60	091.0, 091.3, 092.9, 096, 097.1, 098.0, 098.12, 098.15, 098.6, 098.7, 099.40, 099.41, 099.52, 099.53, 604.90, 608.89, 616.0, 616.50, V01.6	None.
Butoconazole Nitrate 2% vaginal cream 5gm	Female	All except S60	112.1	None.
Clindamycin 2% vaginal cream 5.8gm	Female	All except S60	616.10	None.
Estradiol 0.5mg/1mg/2mg tablets	Female	S10, S20, S30 and S40	None	None.
Podofilox topical solution 0.5%	Both	All except S60	078.0, 078.10, 078.11	None.
Tinidazole 250mg tablets	Both	All except S60	131.01, 131.02, V01.6	Restricted to a maximum quantity per dispensing of eight (8) tablets and a maximum of two (2) dispensings in any 30-day period same provider/any rendering.
Tinidazole 500mg tablets	Both	All except S60	131.01, 131.02, V01.6	Restricted to a maximum quantity per dispensing of four (4) tablets and a maximum of two (2) dispensings in any 30-day period same provider/any rendering.

Note: Miscellaneous drugs for non-surgical procedures are billed with HCPCS code Z7610 under all primary diagnosis codes except S60 when dispensing onsite. This code may be used only by hospital outpatient departments, emergency rooms, surgical clinics and community clinics. Additionally, providers must enter a correct secondary diagnosis ICD-9 code as noted in the table above, and document the name of the medication, the quantity dispensed and the provider's cost per unit in the *Reserved For Local Use* field (Box 19) of the claim or on an attachment. Pharmacies or clinics billing for drugs under a pharmacy license must use National Drug Codes.

Please see **Family PACT**, *page 6*

Family PACT *(continued)*

Restrictions

The following CPT-4 codes are restricted to females ages 10 to 55 years of age: 00940, 57452, 57454, 57455, 57456, 57460, 57511, 87621, 88305 and 88307.

CPT-4 code 58100 is restricted to females 36 to 55 years of age with a diagnosis of 795.00 (atypical glandular cells) and females 40 to 55 years of age with a diagnosis of 795.09 (other abnormal Pap) presenting with certain other clinical findings. (See the "Secondary Diagnosis, Cervical Abnormalities" section of the *2006 Provisional Clinical Services Benefits Grid*.

The following CPT-4 codes are now reimbursable to Non-Physician Medical Practitioners (NMPs): 11976, 56605, 57452, 57455, 57456, 57511, 58100, 58300 and 58301.

CPT-4 code 56605 is limited to females.

CPT-4 code 87205 is limited to males.

CPT-4 codes 87490 and 87590 are limited to reflex testing subsequent to a positive screening test result, and are only reimbursable with or after a paid claim for CPT-4 code 87800.

CPT-4 codes 87181 and 87184 are limited to reflex testing subsequent to a positive test result, and are only reimbursable with or after a paid claim for CPT-4 code 87086.

Urine screening laboratory tests previously available to all clients are now restricted. CPT-4 codes 81000 – 81003 (urine laboratory test), available as pre-operative screening tests for sterilization surgery, are reimbursed using primary diagnosis codes S701-2 (females) and S801-2 (males).

UTI services are reimbursed only for symptomatic females. A primary diagnosis S-code (except S601-2) and at least one of the secondary diagnosis ICD-9 codes are required when billing for diagnostic and treatment services. (See the "Secondary Diagnosis: Urinary Tract Infection [UTI]" section of the *2006 Provisional Clinical Services Benefits Grid.*)

CPT-4 codes 81005, 81015 and 87086 are reimbursed for UTI symptomatic females with a primary diagnosis code of S701-2 and one of the secondary diagnosis codes for UTI.

CPT-4 codes 81000 – 81003, 81005, 81015 and 87086 are reimbursed for symptomatic females with a primary diagnosis code of S101-2, S201-2, S301-2, S401-2 or S501-2 and a secondary diagnosis code for UTI.

CPT-4 codes 80061 and 80076 are limited to once per six months, per client, any provider. (See the *2006 Provisional Clinical Services Benefits Grid*.)

CPT-4 codes 82947 and 82951 are limited to one per year, per client, any provider. (See the *2006 Provisional Clinical Services Benefits Grid*.)

CPT-4 codes 85014 and 85018 are limited to females with an S401-2 or S701-2 diagnosis code.

CPT-4 code 85027 is limited to females with a diagnosis code of S701-2 and males with a diagnosis code of S801-2.

CPT-4 codes 87252, 87255 and 87273 are limited to evaluation of genital ulcers of unconfirmed etiology, and require a secondary diagnosis code of 616.50 for females or 608.89 for males.

CPT-4 code 93000 is limited to S701-2 when medically indicated for pre-operative evaluation of females with a pre-existing cardiovascular condition.

Please see **Family PACT**, *page 7*

Family PACT *(continued)*

Deletions and Replacements
The following prescription drugs are no longer Family PACT benefits:

- Amoxicillin/Clavulanate potassium tablets
- Conjugated Equine Estrogen tablets and capsules
- Diphenhydramine hydrocholoride tablets and capsules
- Famciclovir tablets
- Valacyclovir HCl tablets

Primary diagnosis code S90 is discontinued for both male and female recipients. Consequently, the following CPT-4 codes are no longer benefits: 83001, 84144, 84146, 84443, 89320 and 89330.

The following CPT-4 codes are no longer benefits: 57500, 85004, 85007, 85008, 85032, 85049, 87110, 87164, 87166, 87207, 87270, 87274, 87285, 88150, 88152, 88153, 88154, 88166 and 89300.

The following ranges of secondary diagnosis codes have been replaced by specific ICD-9 codes. (See the *2006 Provisional Clinical Services Benefits Grid* for appropriate use of ICD-9 secondary diagnosis codes):

Chlamydia: Range 099.4-099.59 is replaced with 099.41, 099.52, 099.53, 099.40, 604.90, 616.0 and V01.6.

Gonorrhea: Range 098.0 – 098.89 is replaced with 098.0, 098.12, 098.15, 098.6, 098.7, 099.40, 616.0 and V01.6.

Herpes (genital only): Range 054.10 – 054.19 is replaced with 054.11, 054.12, 054.13, 608.89 and 616.50.

Pelvic Inflammatory Disease: Range 614.0 – 614.9 is replaced with 614.0, 614.2 and 615.0.

Syphilis: Range 091.0 – 097.9 is replaced with 091.0, 191.3, 092.9, 096, 097.1, 616.50, 608.89 and V01.6.

Vaginitis/Vaginal Discharge: Codes 131.00 and 131.09 are deleted.

Warts (genital): Range 078 – 078.19 is replaced with 078.0, 078.10 and 078.11.

Please see **Family PACT**, *page 8*

Family PACT *(continued)*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid

The Family PACT Program *2006 Provisional Clinical Services Benefits Grid* presents the benefits package codes for procedures, medications and contraceptive supplies effective for dates of service on or after August 1, 2006.

Primary Diagnosis: Family Planning Methods

Core Services						Complications Services (5)	
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Diag. Code**	**Description**
S101 S102	Oral contraception, patch, vaginal ring – Evaluation prior to method with or without initiation of method Oral contraception, patch, vaginal ring – Maintain adherence and surveillance	Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered) 76092 Screening Mammogram (6)	• 80061 Lipid profile (1), (2) • 80076 LFTs (2) • 82465 Cholesterol • 81025 Urine pregnancy test • 82947 Glucose (3) • 82951 2hr GTT (3)(4)	None	X7706 OCs X7728 Patch X7730 Vaginal Ring Z7610 Estradiol X7722 Levonorgestrel X1500 Spermicide, lubricant, M/F condom	S103 S1031	Vaso-vagal episode Allergic reaction to treatment for a secondary diagnosis Deep vein thrombosis
S201 S202	Contraceptive injection – Evaluation prior to method with or without initiation of method Contraceptive injection – Maintain adherence and surveillance	Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered) 76092 Screening Mammogram (6)	• 80076 LFTs (2) • 81025 Urine pregnancy test • 82947 Glucose (3) • 82951 2hr GTT (3)(4)	None	X6051 DMPA Z7610 Estradiol X7722 Levonorgestrel X1500 Spermicide, lubricant, M/F condom	S203 S2031	Vaso-vagal episode Allergic reaction to treatment for a secondary diagnosis Heavy vaginal bleeding

The following laboratory tests are for symptomatic or asymptomatic clients as clinically indicated based on individual client assessment. These tests are included under the primary diagnosis and do not require a secondary diagnosis code for reimbursement:

Core Screening Tests		**Reflex Testing Based on a Positive Screening Test Result**		**Pap Smear Codes**	
86592	VDRL, RPR	86781	TP-confirmatory test; if positive, 86593 is required	88141	Physician Interpretation of Pap
		86593	Syphilis test, quantitative	88142	LBC, manual screen
				88143	LBC, manual screen and re-screen
86701	HIV-I	86689	HIV confirmation	88147	Smear, automated screen
86702	HIV-II	86689	HIV confirmation	88148	Smear, automated screen, manual re-screen
86703	HIV-I and HIV-II single assay	86689	HIV confirmation	88164	Smear, Bethesda, manual screen
				88165	Smear, Bethesda, manual screen, re-screen
87081	GC culture	-------	None	88167	Smear, Bethesda, manual screen, computer re-screen
87491	Chlamydia NAAT	-------	None	88174	LBC, automated screen
87591	GC NAAT	-------	None	88175	LBC, automated screen, manual re-screen
87800	Chlamydia +GC direct probe	87490	Chlamydia direct probe		
		87590	GC direct probe	For HPV tests, see Cervical Abnormalities	

(1) Only if elevated screening cholesterol or significant risk factors for cardiovascular disease.
(2) Limited to one every six months per client.
(3) Limited to one per year per client.
(4) Only if history of abnormal fasting blood sugar screen.
(5) Complications services (any Sxx.3 diagnosis code) require a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.
(6) Screening mammography, females 40-55 years of age, one per year per client.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid***, page 9*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Core Services						Complications Services (5)	
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Diag. Code**	**Description**
S301 S302	Contraceptive implant – Evaluation prior to method with or without initiation of method Contraceptive implant – Maintain adherence and surveillance (including removal and reinsertion)	11975 Insertion 11976 Removal 11977 Removal and insertion Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered) 76092 Screening Mammogram (6)	• 80076 LFTs (2) • 81025 Urine pregnancy test	11976ZM Removal supplies	Z7610 Estradiol X7722 Levonorgestrel X1500 Spermicide, lubricant, M/F condom	S303 S3031 S3032 S3033 S3034 S3035	Vaso-vagal episode Allergic reaction to treatment for a secondary diagnosis Missing or deep capsule Insertion/removal site infection Insertion/removal site hematoma Capsule expulsion Heavy vaginal bleeding
S401 S402	IUC – Evaluation prior to method with or without initiation of method IUC – Maintain adherence and surveillance	58300 Insertion 58301 Removal Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered) 76092 Screening Mammogram (6)	• 81025 Urine pregnancy test • 85013, 85014 Hematocrit • 85018 Hemoglobin	58300ZM Insertion supplies 58301ZM Removal supplies	X1522 ParaGard X1532 Mirena IUS Z7610 Estradiol X7722 Levonorgestrel X1500 Spermicide, lubricant, M/F condom	S403 S4031 S4032 S4033	Vaso-vagal episode Allergic reaction to treatment for a secondary diagnosis Pelvic infection (secondary to IUD) "Missing" IUD Perforated or translocated IUD

The following laboratory tests are for symptomatic or asymptomatic clients as clinically indicated based on individual client assessment. These tests are included under the primary diagnosis and do not require a secondary diagnosis code for reimbursement:

Core Screening Tests		**Reflex Testing Based on a Positive Screening Test Result**		**Pap Smear Codes**	
86592	VDRL, RPR	86781	TP confirmatory test; if positive, 86593 is required	88141	Physician Interpretation of Pap
		86593	Syphilis test, quantitative	88142	LBC, manual screen
				88143	LBC, manual screen and re-screen
86701	HIV-I	86689	HIV confirmation	88147	Smear, automated screen
86702	HIV-II	86689	HIV confirmation	88148	Smear, automated screen, manual re-screen
86703	HIV-I and HIV-II single assay	86689	HIV confirmation	88164	Smear, Bethesda, manual screen
				88165	Smear, Bethesda, Manual screen, re-screen
87081	GC culture	-------	None	88167	Smear, Bethesda, manual screen, computer re-screen
87491	Chlamydia NAAT	-------	None	88174	LBC, automated screen
87591	GC NAAT	-------	None	88175	LBC, automated screen, manual re-screen
87800	Chlamydia +GC, direct probe	87490	Chlamydia direct probe		
		87590	GC direct probe		

For HPV tests, see Cervical Abnormalities

(2) Limited to one every six months per client.

(5) Complications services (any Sxx.3 diagnosis code) require a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.

(6) Screening mammography, females 40-55 years of age, one per year per client.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid**, *page 10*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Core Services						Complications Services (5)	
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Diag. Code**	**Description**
S501	Barriers and spermicide – Evaluation prior to method with or without initiation of method **Note:** Includes fertility awareness methods and lactation amenorrhea method	57170 Diaphragm/ cervical cap fitting Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered) 76092 Screening Mammogram (6)	• 81025 Urine pregnancy test	FAM supplies	X7722 Levonorgestrel X1500 Diaphragm, cervical cap, spermicide, lubricant, M/F condom, BBT	S503 S5031	Vaso-vagal episode Allergic reaction to treatment for a secondary diagnosis Severe skin/tissue reaction
S502	Barriers and spermicide – Maintain adherence and surveillance						
S601	Pregnancy testing **Note:** Should be used only when the client is not seeking a contraceptive method		• 81025 Urine pregnancy test **Note:** No additional laboratory tests are available with this core code				
S602	Confirmation of pregnancy test result						

Note: If result is negative and client chooses family planning method, use a method-specific primary diagnosis code.

The following laboratory tests are for symptomatic or asymptomatic clients as clinically indicated based on individual client assessment. These tests are included under the primary diagnosis and do not require a secondary diagnosis code for reimbursement:

Core Screening Tests		**Reflex Testing Based on a Positive Screening Test Result**		**Pap Smear Codes**	
86592	VDRL, RPR	86781	TP confirmatory test; if positive, 86593 is required	88141	Physician Interpretation of Pap
		86593	Syphilis test, quantitative	88142	LBC, manual screen
				88143	LBC, manual screen and re-screen
86701	HIV-I	86689	HIV confirmation	88147	Smear, automated screen
86702	HIV-II	86689	HIV confirmation	88148	Smear, automated screen, manual re-screen
86703	HIV-I and HIV-II single assay	86689	HIV confirmation	88164	Smear, Bethesda, manual screen
				88165	Smear, Bethesda, Manual screen, re-screen
87081	GC culture	-------	None	88167	Smear, Bethesda, manual screen, computer re-screen
87491	Chlamydia NAAT	-------	None	88174	LBC, automated screen
87591	GC NAAT	-------	None	88175	LBC, automated screen, manual re-screen
87800	Chlamydia +GC, direct probe	87490	Chlamydia direct probe		
		87590	GC direct probe	For HPV tests, see Cervical Abnormalities	

(5) Complications services (any Sxx.3 diagnosis code) require a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.
(6) Screening mammography, females 40-55 years of age, one per year per client.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid***, page 11*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Core Services						Complications Services (5)	
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Diag. Code**	**Description**
S701 S702	Bilateral tubal ligation – Screening and Evaluation Surgical procedure	Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered) 58600 Mini lap TL 58615 Mini lap TL with clip 58670 Lapscope fulguration 58671 Lapscope with ring or clip 76092 Screening Mammogram (6)	• 80076 LFTs (2) • 81025 Urine pregnancy test • 88302 Surgical path., (two specimens) **Pre-operative testing** • 81000 UA dipstick w/microscopy • 81001 UA automated w/micro • 81002 UA dipstick w/out microscopy • 81003 UA automated w/out micro • 85013 spun Hct • 85014 Hct • 85018 Hemoglobin • 85025 Auto CBC w/auto diff. WBC • 85027 Auto CBC w/out differential • 93000 Electrocardiogram (A)	58600 ZM/ZN Mini-Lap TL 58615 ZM/ZN Mini-Lap with clip 58670 ZM/ZN Lapscope fulguration 58671 ZM/ZN Lapscope ring or clip	X7722 Levonorgestrel X1500 Spermicide, lubricant, M/F condom	S703 S7031 S7032 S7033 S7034	Vaso-vagal episode Allergic reaction to treatment for a secondary diagnosis Anesthesia complication: hospitalization Abdominal injury; L/S or lap (within 30 days post op) Operative site or pelvic infection (within 30 days post op) Preop evaluation (TAR prospective)

The following laboratory tests are for symptomatic or asymptomatic clients as clinically indicated based on individual client assessment. These tests are included under the primary diagnosis for sterilizations and do not require a secondary diagnosis code for reimbursement:

Core Screening Tests		**Reflex Testing Based on a Positive Screening Test Result**		**Pap Smear Codes**	
86592	VDRL, RPR	86781	TP confirmatory test; if positive, 86593 is required	88141	Physician Interpretation of Pap
		86593	Syphilis test, Quantitative	88142	LBC, manual screen
				88143	LBC, manual screen and re-screen
86701	HIV-I	86689	HIV confirmation	88147	Smear, automated screen
86702	HIV-II	86689	HIV confirmation	88148	Smear, automated screen, manual re-screen
86703	HIV-I and HIV-II single assay	86689	HIV confirmation	88164	Smear, Bethesda, manual screen
				88165	Smear, Bethesda, Manual screen, re-screen
87081	GC culture	-------	None	88167	Smear, Bethesda, manual screen, computer re-screen
87491	Chlamydia NAAT	-------	None	88174	LBC, automated screen
87591	GC NAAT	-------	None	88175	LBC, automated screen, manual re-screen
87800	Chlamydia +GC direct probe	87490	Chlamydia direct probe		
		87590	GC direct probe	For HPV tests, see Cervical Abnormalities	

(2) Limited to one every six months per client.
(5) Complications services (any Sxx.3 diagnosis code) require a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.
(6) Screening mammography, females 40-55 years of age, one per year per client.
(A) As medically indicated for preoperative evaluation of a woman with a pre-existing cardiovascular condition.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid**, *page 12*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Core Services						Complications Services (5)	
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Diag. Code**	**Description**
S801 S802	Vasectomy – Screening and evaluation Surgical procedure	Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered) 55250 Vasectomy	• 88302 Surgical path (two specimens) **Pre-operative tests** • 81000 UA dipstick w/microscopy • 81001 UA automated w/micro • 81002 UA dipstick w/out microscopy • 81003 UA automated w/out micro • 85013 spun Hct • 85014 Hct • 85018 Hemoglobin • 85025 Auto CBC w/auto diff.WBC • 85027 Auto CBC w/out differential	55250 ZM Supplies	X1500 Spermicide, lubricant, M/F condom	S803 S8031 S8032 S8033	Vaso-vagal episode Allergic reaction to treatment for a secondary diagnosis Testicular, spermatic cord hematoma, or hemorrhage (within 30 days post op) Operative site acute infection (within 30 days post-op) Post-op testicular pain (within 30 days post-op)

Post vasectomy semen analysis is included in the global fee for vasectomy.

The following laboratory tests are for symptomatic or asymptomatic clients as clinically indicated based on individual client assessment. These tests are included under the primary diagnosis for sterilizations and do not require a secondary diagnosis code for reimbursement:

Core Screening Tests	
86592	VDRL, RPR
86701	HIV-I
86702	HIV-II
86703	HIV-I and HIV-II single assay
87081	GC culture
87491	Chlamydia NAAT
87591	GC NAAT
87800	Chlamydia +GC direct probe

Reflex testing Based on a Positive Screening Test Result	
86781	TP confirmatory test; if positive, 86593 is required
86593	Syphilis test, quantitative
86689	HIV confirmation
86689	HIV confirmation
86689	HIV confirmation
-------	None
-------	None
-------	None
87490	Chlamydia direct probe
87590	GC direct probe

(5) Complications services (any Sxx.3 diagnosis code) require a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid**, *page 13*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Secondary Diagnosis: Sexually Transmitted Infection (STI)

A secondary diagnosis for STIs is required for treatment or diagnostic testing other than the previously listed core screening tests. HIV testing is a core screening service, but treatment is not a covered benefit of the program.

Core Secondary Services (8)						Complications Services (10)
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications (7)**	**Description**
V01.6	Use V01.6 for diagnosis and treatment of an asymptomatic partner exposed to active case of Chlamydia, Gonorrhea, Syphilis, or Trichomoniasis.		Core screening tests, wet mounts, and pH testing only	Treatment is based on the CDC STD treatment guidelines for the STI identified in the index case.		
  099.41 099.52 099.53 099.40 604.90 616.0 V01.6	Chlamydia Urethritis Anus/rectum Cervicitis Presumptive Dx Male - NGU/NSU Acute epididymitis/ orchitis Female – cervicitis Ct-exposed partner	None	• 87205 Gram stain- symptomatic males only Chlamydia screening tests included in primary diagnosis	None	Azithromycin Doxycycline Ofloxacin	Allergic reaction to antibiotics used to treat STI Vaso-vagal episode
  098.0 098.12 098.15 098.6 098.7 099.40 616.0 V01.6	Gonorrhea Urethritis Prostatitis Cervicitis Pharynx Anus/rectum Presumptive Dx Male - NGU/NSU Female - cervicitis GC-exposed partner	None	• 87205 Gram stain- symptomatic males only GC screening tests included in primary diagnosis	None	Azithromycin (9) Cefpodoxime Ceftriaxone Ciprofloxacin Ofloxacin	Allergic reaction to antibiotics used to treat STI Vaso-vagal episode
   054.11 054.12 054.13 608.89 616.50	Herpes (genital only) HSV vulvovaginitis Herpes vulva Herpes penis Presumptive Dx Male – penile ulcer Female – vulvar ulcer	None	**Additional Restrictions Apply (11)** • 87252 HSV culture • 87255 HSV culture • 87273 HSV DFA Type II	None	Acyclovir	Allergic reaction to antibiotics used to treat STI Vaso-vagal episode
    614.0 614.2 615.0	PID (uncomplicated outpatient only) Acute PID PID, NOS Acute myometritis	Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered)	• 85025 CBC/diff • 85651 ESR • 85652 ESR Chlamydia and GC screening tests are included in primary diagnosis	None	Ceftriaxone injection Cefoxitin injection Doxycycline Metronidazole Ofloxacin Probenecid	Allergic reaction to antibiotics used to treat STI Vaso-vagal episode

(7) Only dosage regimens included in current CDC STD Treatment Guidelines or California STD Treatment Guidelines may be used. See **www.dhs.ca.gov/ps/dcdc/STD/stdindex.htm.** See the Family PACT Pharmacy Formulary for additional information on regimen, formulation and coverage limits.
(8) Secondary diagnosis required for any treatment or diagnostic testing beyond core screening tests.
(9) For patients with significant anaphylaxis-type allergies to penicillin or allergies to cephalosporins.
(10) Complications services for a secondary diagnosis require a primary diagnosis code (Sxx.3) and a TAR. See *Family PACT: Treatment Authorization Request (TAR)* section.
(11) Only as necessary to evaluate genital ulcers of unconfirmed etiology; payable for 616.50 (F) or 608.89 (M) only. Reflex typing is not covered.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid**, *page 14*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Core Secondary Services (8)						Complications Services (10)
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications (7)**	**Description**
091.0 091.3 092.9 096 097.1 616.50 608.89 V01.6	Syphilis Primary Secondary Early latent Late latent Latent, unspecified <u>Presumptive Dx</u> Female –vulvar ulcer Male – penile ulcer Syphilis-exposed partner	Z5218 Collection and handling of blood specimen (when only service rendered) Z5220 Collection and handling of blood specimen (when other services rendered)	• 86593 Syphilis test quantitative (12) Syphilis screening tests included in Primary Diagnosis	None	Benzathine penicillin long acting - injection Azithromycin Doxycycline	Allergic reaction to antibiotics used to treat STI Vaso-vagal episode
131.01 131.02 V01.6	Trichomoniasis Trichomonal vulvo-vaginitis Trich. Urethritis Trichomoniasis-exposed partner	None	• 83986 pH – females only • 87210 Wet mount	None	Metronidazole Tinidazole (15)	
112.1 616.10	Vulvovaginitis Candidal Vulvo-vaginitis Vaginitis/Vulvitis/ BV	None	• 83986 pH – females only • 87210 Wet mount	None	Butoconazole Clotrimazole Fluconazole Miconazole Terconazole Clindamycin Metronidazole	Allergic reaction to antibiotics used to treat STI Vaso-vagal episode
078.0 078.10 078.11	Warts (genital only) Molluscum Viral warts Condylomata	54050 Destruction of penile lesion (13) 54056 Destruction of penile lesion (13) 54100 Biopsy of penis (14) 56501 Destruction vulvar lesion (13) 57061 Destruction vaginal lesion (13) 56605 Biopsy, vulva (14)	• 88304 Surgical path for males (14) • 88304 Surgical path for females(14)	• 54050ZM Penile supplies • 54056ZM Penile supplies • 54100ZM Biopsy supplies • 56501ZM Vulvar supplies • 57061ZM Vaginal supplies • 56605ZM Biopsy supplies	Imiquimod Podofilox	Allergic reaction to antibiotics used to treat STI Severe genital skin ulcerations or infections Vaso-vagal episode

(7) Only dosage regimens included in current CDC STD Treatment Guidelines or California STD Treatment Guidelines may be used. See **www.dhs.ca.gov/ps/dcdc/STD/stdindex.htm**. See the Family PACT Pharmacy Formulary for additional information on regimen, formulation and coverage limits.
(8) Secondary diagnosis required for any treatment and/or diagnostic testing beyond screening.
(10) Complications services for a secondary diagnosis require a primary diagnosis code (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.
(12) Only as necessary to confirm response to syphilis treatment; should not be ordered with presumptive diagnosis codes.
(13) Supply charges for these procedures include the TCA/BCA, liquid nitrogen, or Podophyllin used.
(14) Only as necessary to confirm vulvar, vaginal or genital warts in a wart treatment candidate.
(15) Only as a treatment for vaginal trichomoniasis if treatment failure or adverse effects (but not allergy) with prior use of Metronidazole.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid**, *page 15*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Secondary Diagnosis: Urinary Tract Infection (UTI)
A secondary diagnosis is required for UTI laboratory tests for female recipients only.

Other Secondary Services						Complications Services (10)
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Description**
	UTI	None	• 81000 UA dipstick w/microscopy	None	Cephalexin	Allergic reaction to antibiotics used to treat UTI
595.0	Acute cystitis		• 81001 UA automated w/microscopy		Ciprofloxacin	
599.7	Hematuria				Nitrofurantoin	Vaso-vagal episode
788.1	Dysuria		• 81002 UA dipstick w/out microscopy		TMP/SMX	
788.41	Urinary frequency					
789.09	Abdominal pain, bilateral		• 81003 UA automated w/out microscopy			
			• 81005 UA (qualitative)			
			• 81015 Urine microscopy			
			• 87086 Urine culture			
			• 87181, 87184, 87186 sensitivity			

(10) Complications services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid**, *page 16*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Secondary Diagnosis: Cervical Abnormalities

A secondary diagnosis code is required for cervical abnormality diagnostic and treatment services. These services are restricted to female clients aged 15 to 55 years.

Other Secondary Services						Complications Services (10)
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Description**
795.01 795.02 795.03 795.04 795.05 622.2	ASC-US Pap ASC-H Pap LGSIL Pap HGSIL Pap Abn Pap with HPV high risk pos. Presumptive Dx. Leukoplakia, cervix	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies	None	Pelvic infection resulting from cervical treatment Hemorrhage from cervical biopsy or treatment site requiring surgical repair Vaso-vagal episode
795.00	AGC Pap	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 58100 Endometrial biopsy (19)	• 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 58100ZM Supplies	None	
622.11 622.12 233.1	CIN I (biopsy) CIN II (biopsy) CIN III (biopsy)	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 57511 Cryocautery of cervix (16) 57460 LEEP (16)	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology • 88307 Surgical pathology (17)	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 57511ZM Supplies 57460ZM Supplies	None	
795.09	Other abnormal Pap	58100 Endometrial biopsy (20)	• 88305 Surgical pathology			

(10) Complications services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.

(16) Restricted to biopsy proven CIN II or CIN III or persistent CIN I lesions of greater than 12 months.

(17) Restricted to biopsy specimens collected by LEEP procedure.

(18) DNA Amplified Probe HPV (High Risk Only) is covered in the following circumstances (see ASCCP, Guidelines 2002) and limited to one per year per client:
- Reflex HPV DNA testing after an ASC-US cytology result.
- Follow-up of LSIL cytology result in women less than 21 years of age. HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post-colposcopy; Women with Paps read as ASC-H, LSIL, or HPV DNA positive ASC-US in whom CIN is not identified at colposcopy can be followed up at 12 months with HPV DNA testing in lieu of cytology at 6 and 12 months.
- Follow-up of women with biopsy proven untreated CIN I; HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post treatment of CIN II, III: HPV DNA test at least six months after treatment in lieu of follow-up cytology.

DNA Amplified Probe HPV testing is not covered for a diagnosis of HGSIL Pap, ICD-9 795.04 or Leukoplakia cervix, ICD-9 622.2.

(19) Endometrial biopsy is covered only if AGC (atypical glandular cells) cytology result and any of:
- "Atypical endometrial cells" on AGC cytology result.
- Woman is having abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer.
- Woman is 36 through 55 years of age.

(20) Endometrial biopsy restricted to women aged 40 years or older with a finding of endometrial cells on Pap and a recent history of menstrual irregularity.

Please see **Family PACT Program 2006 Provisional Clinical Services Benefits Grid***, page 17*

Family PACT Program 2006 Provisional Clinical Services Benefits Grid *(continued)*

Core Secondary Service: Immunization
A secondary diagnosis is required for administration of Hepatitis B vaccine to non-immunized clients.

Other Secondary Services						Complications Services (10)
Vaccine	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Description**
Hepatitis B Use appropriate primary diagnosis code	Hepatitis B immunization		None	None	Hepatitis B vaccine 90743 90744 90746 Modifiers required	Allergic reaction to Hepatitis B vaccine Vaso-vagal episode

(10) Complications services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.

Family PACT Provisional Secondary Core Services Drugs and Supplies
The following table lists all Family PACT secondary core service drugs and supplies.

Medication	Dosage Size	Regimens	Clinic Code	Notes
Bacterial vaginosis				
Metronidazole	250mg/500mg tabs	500mg PO BID X 7 days	Z7610	recommended regimen
Metronidazole	0.75% vaginal gel	5g PV qhs X 5 days	Z7610	recommended regimen
Clindamycin	2% cream	5g PV X 7 days	Z7610	recommended regimen
Clindamycin	150mg capsules	300mg PO BID X 7 days	Z7610	alternative regimen
Clindamycin	2% SR cream	1 applicator PV X 1	Z7610	alternative regimen
Chlamydia				
Azithromycin	500mg tabs/1gm packet	1gm PO X 1	Z7610	recommended regimen
Azithromycin	250mg tabs	1gm PO X 1	X7716	recommended regimen
Doxycycline	100mg tabs	100mg PO BID X 7days	Z7610	recommended regimen
Ofloxacin	300mg tabs	300mg PO BID X 7 days	Z7610	alternative regimen
External Genital Warts				
Imiquimod	5% cream	3 days/wk X up to 16 weeks	Z7610	
Podofilox	0.5% solution/gel	3days/wk X up to 4 weeks	Z7610	
Genital Herpes				
Acyclovir	200mg tabs	200mg PO 5/day X 5 or 10 days	Z7610	primary or recurrent herpes
Acyclovir	400mg tabs	400mg PO TID X 5 or 10 days	Z7610	primary or recurrent herpes
Acyclovir	800mg tabs	800mg PO BID X 5 days	Z7610	recurrent herpes
Acyclovir	400mg tabs	400mg PO BID	Z7610	chronic suppression
Gonorrhea				
Ceftriaxone	250mg injection	125mg IM X 1	X5864	recommended regimen
Azithromycin	500mg tabs/1gm packet	2gm PO X 1	Z7610	alternative regimen
Azithromycin	250mg tabs	2gm PO X1	X7716	alternative regimen
Cefpodoxime	200mg tabs	400mg PO X1	Z7610	alternative regimen
Ciprofloxacin	250/500mg tabs	500mg PO X 1	Z7610	alternative regimen
Ofloxacin	400mg tabs	400mg PO X 1	Z7610	alternative regimen

Please see **Family PACT**, *page 18*

Family PACT *(continued)*

Medication	Dosage Size	Regimens	Clinic Code	Notes
PID/Myometritis				
Cefoxitin	1gm/2gm injection	2gm IM x1	X5854	recommended regimen
Ceftriaxone	250mg injection	250mg IM X 1	X5864	recommended regimen
Doxycycline	100mg tabs	100mg PO BID X 14 days	Z7610	recommended regimen
Metronidazole	250/500mg tabs	500mg PO BID X 14 days	Z7610	alternative regimen
Ofloxacin	400mg tabs	400mg PO BID X 14 days	Z7610	alternative regimen
Probenecid	500mg tabs	1gm PO X 1	Z7610	for use with Cefoxitin
Syphilis				
Benzathine penicillin	1.2mill units/ cc	2.4 mil. Units IM X 1	X7460	recommended regimen
Benzathine penicillin	2.4 mill units/ cc	2.4 mil. Units IM q wk X 1-3 doses	X7462	recommended regimen
Doxycycline	100mg tabs	100mg PO BID X 4 weeks	Z7610	alternative regimen
Azithromycin	500mg tabs/1g packet	2g PO X 1	Z7610	alternative regimen
Azithromycin	250mg tabs	2g PO X 1	X7716	alternative regimen
Metronidazole	500mg tabs	2g PO x 1	Z7610	recommended regimen
Trichomoniasis				
Metronidazole	500mg tabs	500mg PO BID X 7 days	Z7610	alternative regimen
Tinidazole	250mg/500mg tabs	2g PO X 1	Z7610	alternative regimen
Urinary Tract Infection - Guidelines based on American Academy of Family Physicians Vol. 72/No. 3 (August 1, 2005)				
Cephalexin	250mg tabs	250mg PO QID X 7 - 10 days	Z7610	
Cephalexin	500mg tabs	500mg PO BID X 7 - 10 days	Z7610	
Ciprofloxacin	250mg tabs	250mg PO BID X 3 days	Z7610	
Ciprofloxacin	500mg SR tabs	500mg PO QD X 3 days	Z7610	
Nitrofurantoin	50mg/100mg tabs	100mg PO BID X 7 - 10 days	Z7610	
TMP/SMX	80/400mg tabs	80/400mg 2 PO BID X 3 days	Z7610	
TMP/SMX DS	160/800mg tabs	160/800 PO BID X 3 days	Z7610	
Vaginal candidiasis - see CDC, Sexually Transmitted Diseases Treatment Guidelines 2002, MMWR 2002:51 for treatment regimens				
Butoconazole	2% cream/ 2% SR cream		Z7610	
Clotrimazole	1% cream/ 100mg/ 200mg/ 500mg vaginal tablets		Z7610	
Fluconazole	150mg tablet		Z7610	
Miconazole	2% cream/ 100mg/ 200mg vaginal suppository		Z7610	
Terconazole	0.4%/ 0.8% cream/ 80mg suppository		Z7610	

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Vision Care HIPAA Updates Effective July 1, 2006 Summary

Effective for dates of service on or after July 1, 2006, the following changes will be made to the Medi-Cal Vision Care Program, pursuant to the Health Insurance Portability and Accountability Act (HIPAA):

- Convert Medi-Cal interim codes to national HCPCS Level II and CPT-4 Level I codes.
- Eliminate all Medi-Cal qualifying codes and replace them with national CPT-4 and HCPCS modifiers. Additionally, modifiers X1 – X9 are no longer used for vision services.
- Replace the *Payment Request for Vision Care and Appliances* (45-1) claim form with the *HCFA 1500* claim form.
- Replace the current Treatment Authorization Request (TAR) process for medically necessary contact lenses, low vision aids and other non-Prison Industry Authority (PIA) covered items using the 45-1 claim form, with a new process using the *50-3 Treatment Authorization Request* (TAR) form.
- Replace Medi-Cal's Computer Media Claims (CMC) proprietary format with the ASC 12XN 837 v.4010A1 medical format or Internet Professional Claims Submission (IPCS).

Policy for all updates was announced in the May 2006 *Medi-Cal Update*. Updates are reflected in manual replacement pages *appeal form 1 and 2* (Part 2), *children 3 and 4* (Part 2), *hcpcs iii 3 and 4* (Part 2), *medi non cpt 1* (Part 2), *medi non hcp 1 thru 3* (Part 2), *ophthal 1 thru 6* (Part 2), *ophthal cd 1 thru 5* (Part 2), *prescript vc 1 and 2* (Part 2) and *surg 5 and 6* (Part 2).

Record Keeping Update for Billing Eye Appliances

Effective for dates of service on or after July 1, 2006, *Welfare and Institutions Code* (W&I Code), Section 14043.341 requires providers to obtain and keep a record of Medi-Cal recipients' signatures when dispensing a product or prescription or when obtaining a laboratory specimen.

Optical providers who dispense eye appliances requiring a written order or prescription must maintain the following items in their files to qualify for Medi-Cal reimbursement:

- Signature of the person receiving the eye appliance
- Medi-Cal recipient's printed name and signature
- Date signed
- Prescription number or item description of the eye appliance dispensed
- Relationship of the recipient to the person receiving the prescription if the recipient is not picking up the appliance

This information is reflected on manual replacement page ophthal 6 (Part 2).

Reminder for Providers Transitioning to Internet Professional Claim Submission (IPCS) for Vision Claim Submissions

The IPCS system is only available for vision claims with dates of service on or after July 1, 2006.

Effective July 1, 2006, the Vision CMC proprietary claims transaction format will no longer be accepted for vision services, regardless of the date of service. Providers who have chosen to transition to the HIPAA-compliant 837 Internet Professional Claim Submission (also known as the 837 Professional Standard Claim on the Internet) are reminded that the IPCS system is only available for claims with dates of service on or after July 1, 2006. For dates of service prior to this, providers must use one of two alternative billing methods:

Option 1 – 837 Claims Submission
The ASC X12N 837 v.4010A1 transaction may be used for claims with dates of service prior to July 1, 2006; however, the required testing must have already been completed and approved. If the required testing was not completed and approved, providers must then submit paper claims (see Option 2, below).

Option 2 – Paper Claims Submission
Providers may submit paper claims for dates of service before July 1, 2006 using the *Payment Request for Vision Care and Appliances* (45-1). For paper claims submitted on or after July 1, 2006, providers must use the *HCFA 1500* claim form.

Surgical Implant Procedure Billing Clarification

Providers are reminded that all information that is currently required on an invoice, including the date of surgical implant procedure, is now also allowable on attachments when billing for surgical implantable devices.

The invoice must be on company letterhead from the implant supplier, not the hospital. The hospital must also provide the following whether it is on an invoice or attachment.

- Recipient's full name
- Recipient's Medi-Cal number
- Physician's name
- Facility name where the implant procedure occurred
- Company contact information

Claims for surgical implants without all the above information will be denied.

This information is reflected on manual replacement pages surg 5 and 6 (Part 2).

ICD-9 Codes Required for Clinical Laboratory Tests

Ordering practitioners are reminded to use the most specific or highest level ICD-9 diagnosis codes available when submitting claims to Medi-Cal for laboratory tests. Clinical laboratory providers must report on their claims the diagnostic code(s) furnished by the ordering practitioner for clinical laboratory tests covered by Medi-Cal. If the claim is missing the correct code, the clinical laboratory may determine the appropriate diagnostic code based on the ordering practitioner's narrative diagnostic statement or seek diagnostic information from the ordering practitioner.

Ordering practitioners are also reminded that in accordance with Section 4317 of the federal Balanced Budget Act of 1997, Medicare established a new requirement on claims submitted to Medicare carriers. This requirement also applies to claims submitted to Medi-Cal. Physicians and other ordering practitioners must provide diagnostic or other medical information to the clinical laboratory at the time tests are ordered on biologic specimens. This information must include the most appropriate ICD-9 code(s) for all orders and referrals. Ordering practitioners must provide this information to the clinical laboratory so it may bill for these services.

New Medi-Cal Provider Numbers for 23 Public Hospitals

Starting May 22, 2006 and effective for dates of service on or after July 1, 2005, all physicians and non-physician practitioners billing for inpatient services in the hospitals listed below are required to use a modified provider number in the facility identification field (Box 32) of the *HCFA 1500* claim form.

Background
Senate Bill 1100 (Chapter 560, Statutes of 2005) requires the California Department of Health Services (CDHS) to change the reimbursement methodology for 23 public hospitals. Negotiated rates will be replaced with cost-based, per-diem rates, with Certified Public Expenditures (CPEs) as the basis for the non-federal share of reimbursement. This change covers contract inpatient care rendered to Medi-Cal recipients and uninsured individuals, for dates of service on or after July 1, 2005 through August 31, 2010.

Purpose
To facilitate the capture of costs for services rendered, hospital contract inpatient provider numbers are being modified. The new provider numbers are the same as the current contract provider numbers, except that the last letter "G", "F" or "H" is replaced by "W."

Hospital Name	Current Contract Inpatient Provider Number	Modified Inpatient Provider Number
University of California Davis Medical Center	HSC00599G	HSC00599W
University of California Irvine Medical Center	HSC30348G	HSC30348W
University of California San Diego Medical Center	HSC30025F	HSC30025W
University of California San Francisco	HSC00454G	HSC00454W
University of California Los Angeles Medical Center	HSC30262F	HSC30262W
University of California Los Angeles Santa. Monica	HSC30112H	HSC30112W
Los Angeles County Harbor/UCLA Medical Center	HSC30376F	HSC30376W
Los Angeles County Martin Luther King Jr./Drew Medical Center	HSC30578F	HSC30578W
Los Angeles County Olive View Medical Center	HSC30040G	HSC30040W
Los Angeles County Rancho Los Amigos National Rehab. Center	HSC32014F	HSC32014W
Los Angeles County USC Medical Center	HSC30373F	HSC30373W
Alameda County Medical Center	HSC00320F	HSC00320W
Arrowhead Regional Medical Center	HSC30245F	HSC30245W
Contra Costa Regional Medical Center	HSC00276F	HSC00276W
Kern Medical Center	HSC30315F	HSC30315W
Natividad Medical Center	HSC00248F	HSC00248W
Riverside County Regional Medical Center	HSC30292F	HSC30292W
San Francisco General Hospital	HSC00228F	HSC00228W
San Joaquin General Hospital	HSC00167F	HSC00167W
San Mateo Medical Center	HSC00113F	HSC00113W
Santa Clara Valley Medical Center	HSC00038F	HSC00038W
Tuolumne General Hospital	HSC00325F	HSC00325W
Ventura County Medical Center	HSC39008F	HSC39008W

Enrollment Limitations for Cancer Detection Programs: Every Woman Counts

This notice affects Cancer Detection Programs: Every Woman Counts providers with a Category of Service (COS) 115 and 072. COS 115 providers are enrolled Cancer Detection Programs: Every Woman Counts providers who render both breast and cervical cancer screening services to women. COS 072 providers are enrolled Cancer Detection Programs: Every Woman Counts providers who render breast screening services only.

Due to Centers for Disease Control (CDC) restrictions effective June 30, 2006, Cancer Detection Programs: Every Woman Counts COS 115 providers will not be able to schedule and enroll new women into the program for cervical services. These providers now may only provide Cancer Detection Programs: Every Woman Counts cervical screening services to women currently enrolled in the program, or to returning women who have been enrolled in the past and were issued a recipient ID via the Cancer Detection Programs: Every Woman Counts Internet application. Additionally, a COS 115 provider may continue to schedule cervical screening appointments through June 29, 2006, even if the appointment falls beyond June 30, 2006. For breast screening services only, COS 115 providers may continue to enroll new women. Due to CDC restrictions, the Cancer Detection Section will be monitoring the enrollment Web site very closely for new recipient IDs. Evidence of a new recipient ID issued for a new enrollment into Cancer Detection Programs: Every Woman Counts for cervical screening services will result in disenrollment of the provider from Cancer Detection Programs: Every Woman Counts.

COS 072 providers may continue to enroll new women into the Cancer Detection Programs: Every Woman Counts program for breast screening services only. COS 072 providers must not refer women new to Cancer Detection Programs: Every Woman Counts to COS 115 providers for cervical services.

Cancer Detection Programs' Notice of Privacy Practices Update

The English and Spanish versions of the Notice of Privacy Practices Statements (included with the *Consent to Participate in Program and Privacy Statement* forms) are updated. To access these forms on the Medi-Cal Web site (**www.medi-cal.ca.gov**), click "Cancer Detection" from the home page, then click the appropriate "Consent to Participate in Program and Privacy Statement" link.

The updated information is reflected in the Consent to Participate in Program and Privacy Statement (Part 2).

Cancer Detection Programs: Every Woman Counts 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Level Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine financial eligibility for applicants of Cancer Detection Programs: Every Woman Counts. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table. For additional Cancer Detection Programs: Every Woman Counts information, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Family Members Living in Household	Monthly Gross Household Income	Annual Gross Household Income
1	$1,634	$19,608
2	$2,200	$26,400
3	$2,767	$33,204
4	$3,334	$40,008
5	$3,900	$46,800
6	$4,467	$53,604
7	$5,034	$60,408
8	$5,600	$67,200
For each additional member, add:	$567	$6,804

This information is reflected on manual replacement page can detect 8 (Part 2).

CCS Service Code Groupings (SCG) Update

Effective for dates of service on or after July 1, 2006, a number of codes are added to the California Children's Services (CCS) Service Code Grouping (SCG) 06. The effective date for these codes is designated by the symbol "^".

Codes 99222 and 99223 were previously added to SCG 06 in error, and are end-dated for dates of service on or after July 1, 2006.

Reminder: SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01, 02 and 03. These same "rules" apply to end-dated codes.

The updated information is reflected on manual replacement page cal child ser 17 (Part 2).

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. Dates for the upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client-education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

Sacramento

June 21, 2006
California Department of Health
Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

Ventura

July 13, 2006
Crown Plaza Ventura Beach
450 East Harbor Boulevard
Ventura, CA 93001

Fullerton

July 20, 2006
California State University
Fullerton
TSU Building, Pavilion A
800 N. State College Boulevard
Fullerton, CA 92813

Los Angeles

August 14, 2006
Radisson Wilshire Plaza Hotel
3515 Wilshire Boulevard
Los Angeles, CA 90010

San Diego

August 24, 2006
Manchester Grand Hyatt
One Market Place
San Diego, CA 92101

For a map and directions for these locations, go to the Family PACT Web site at **www.familypact.org** and click the date of the orientation session for an Acrobat file. In the Acrobat file, click the "For Directions: Click Here" link.

Please see **Family PACT Orientation**, *page 25*

Family PACT Orientation *(continued)*

Registration
To register for an Orientation and Update session, go to the Family PACT Web site at **www.familypact.org** and click the appropriate date under "Orientation Sessions" and print a copy of the registration form. Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs, Drugs: Contract Drugs List Part 2 – Over-the-Counter Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs.*

Additions, effective June 1, 2006

Drug	**Size and/or Strength**
CANDESARTAN CILEXETIL	
+ Tablets	4 mg
	8 mg
	16 mg
	32 mg
SUNITINIB MALATE	
Capsules	12.5 mg
	25 mg
	50 mg

Changes, effective June 1, 2006

Drug	**Size and/or Strength**
FLUTICASONE PROPIONATE	
Oral Inhaler (without chlorofluorocarbons as the propellant)	
44 mcg/actuation	**10.6 Gm**
110 mcg actuation	**12 Gm**
220 mcg actuation	**12 Gm**
LITHIUM CARBONATE	
Tablets	300 mg
Capsules	300 mg
* Tablets, Long-Acting	300 mg
(NDC labeler code 68968 [JDS Pharmaceuticals] only.)	
METFORMIN HYDROCHLORIDE	
+ Tablets	500 mg
	850 mg
	1000 mg
+ Tablets, extended release (SCOT delivery system)	500 mg
	1000 mg
(NDC labeler code 62022 [Andrx Laboratories, Inc.] **and 59630 [FIRST HORIZON PHARMACEUTICAL CORP.]** only.)	
+ Tablets, extended release	500 mg
Solution, oral	100 mg/cc

+ Frequency of billing requirement

Instructions for Manual Replacement Pages — Part 2

June 2006

General Medicine Bulletin 383

Remove and replace:	*Contents for General Medicine Billing and Policy* i/ii, v/vi * appeal form 1/2 cal child ser 17/18 can detect 7/8
Remove and replace after *Cancer Detection Programs: Every Woman Counts – Recipient Eligibility Form* (Spanish form)	*Consent to Participate in Program and Privacy Statement* (English form) and *Notice of Privacy Practices* (English)
Remove and replace:	children 3/4 hcpcs iii 3/4 inject 9/10, 37 thru 40 inject list 9 thru 12, 15/16 inject vacc 1 medi non cpt 1 medi non hcp 1 thru 3 medne tele 1 thru 7
Remove: Insert:	modif app 3 thru 10 modif app 3 thru 9
Remove and replace:	non ph 11/12 ophthal 1 thru 6
Insert after the *Ophthamology* section	ophthal cd 1 thru 5 *(new)*
Remove and replace:	prescript vc 1/2
Remove: Insert:	surg 5 surg 5/6
Remove and replace:	tar and non cd9 1/2 vaccine 3 thru 6

* Pages updated due to ongoing provider manual revisions.